STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155145	A. BUILDING _____ B. WING _____	03/17/2011

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F0000	This visit was for the investigation of Complaint IN00087294. This visit was in conjunction with the PSR (Post Survey Revisit) to the Recertification and State Licensure Survey and Investigation of Complaint IN00085424 completed on January 27, 2011. Complaint IN00087294 - Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226. Survey Date: March 17, 2011 Facility Number: 000068 Provider Number: 155145 AIM Number: 100274980 Survey Team: Marla Potts RN, TC Amy Wininger, RN Sharon Whiteman, RN Census Bed Type: SNF: 12 SNF/NF: 79 Total: 91 Census Payor Type: Medicare: 13 Medicaid: 64	F0000	FACILITY LETTERHEAD DATE Please find enclosed the plan of correction for the survey ending __(DATE)_____.Due to the low scope and severity of the survey findings, please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me. Respectfully, ADMNISTRAT OR SIGNATURE TYPED ADMINISTRATOR NAMEAdministrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Other: 14 Total: 91 Sample: 11 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 3/23/11 by Suzanne Williams, RN			

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F0225 SS=D	Based on interview and record review, the facility failed to ensure a resident's (Resident #A) allegation of staff verbal and physical abuse was reported immediately. This affected 1 of 5 residents reviewed for abuse allegations in a sample of 11. Findings include: Interview of LPN (charge nurse) #2 on 03/17/11 at 9:10 a.m. indicated LPN #2 observed therapy working with Resident #A on 03/09/11. Therapy was attempting to get the resident to stand. LPN #2 indicated she (LPN #2) also was encouraging the resident to stand. LPN #2 indicated CNA #3 walked by, and Resident #A pointed to the CNA #(3) and said, "There she is." Interview of LPN #2 on 03/17/11 at 12:20 p.m. indicated on 03/09/11 Resident #A had eaten breakfast before CNA #1 and CNA #3 toileted the resident. LPN #2	F0225	Submission of this Plan of Correction does not constitute and admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.The Plan of Correction is prepared and submitted because of requirements under State and Federal law.Please accept this Plan of Correction as our credible allegation of compliance.F225 ABUSE/NEGLECT REPORTED TO ADMINISTRATIONThe facility will ensure this requirement is met through the following corrective measures:1. Resident #A was not harmed.2. All residents have the potential to be affected. Residents were interviewed as part of the facility's investigation and no concerns were noted at this time. 3. The Policy and Procedure for Resident Abuse and for Reporting Unusual Occurrences was reviewed and no changes are indicated. The staff have been re-educated on the policies and procedures for reporting abuse (See Attachment A). All allegations of abuse will be reported immediately by staff to the Administrator. One staff member will be questioned by the Administrator or designee daily on scheduled work days x4 weeks, then two times weekly x 4 weeks, and then twice monthly thereafter to ensure continued	03/31/2011

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	indicated breakfast was served between 8:00 and 9:00 a.m., and the resident was taken to therapy at approximately 10:00 a.m. LPN #2 indicated CNA #1 and CNA #3 had toileted the resident before therapy. LPN #2 indicated CNA #1 was not standing nearby when the resident pointed and accused CNA #3. LPN #2 indicated CNA #1 did not report anything to LPN #2. LPN #2 indicated the CNAs were aware they were supposed to report any type of abuse immediately to the charge nurse and "for something as urgent as this" they definitely should report it. LPN #2 said, "I am always here (on the unit Resident #A) resided and if for some reason I am not here they know to report it to someone. LPN #2 indicated CNA #3 continued to work and take care of other residents after toileting Resident #A. An investigative sheet, dated 03/09/11, indicated, "To whom		compliance (See Attachment B).4. The findings of these interviews will be reviewed during the facility's quarterly Quality Assurance Meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 3/31/11.	

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	concerned, Resident (#A) confided in me that (CNA #3) was being mean to her this morning during transfers and ADL (activities of daily living) care. (Resident #A) stated to me 'this morning when I was getting up out of bed they pulled my arms and that (CNA #3) said Je--s Chr---, if you don't do it now you never will.' I asked (Resident #A) if her belt (gait belt) was on and she said 'yes but the (sic) still pull on my arms especially that one' (points to CNA #3). 'When I was in the wash room this morning they were again pulling on my arms and I keep telling them it hurts' (sic) (Resident #A) could not state (CNA #3's) name but when passed her in the hall she pointed at her and said 'see there she goes, get her away from me, I'm afraid of her.'" This statement was signed by LPN #2 (Charge Nurse on the hall where Resident #A resided). Interview of the Administrator on			

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	3/17/11 at 11:40 a.m. indicated CNA #3 was released for unprofessional behavior. Interview of Speech Therapist #4 on 03/17/11 at 10:20 a.m. indicated Resident #A was brought to Speech Therapist #4 after being toileted. Speech Therapist #4 indicated, "I could tell (Resident #A) was a little upset. I asked if she (Resident #A) was ok and (Resident #A) said that nurse and described her and I knew who it was by the description and then (Resident #A) said, "Can I write a report if there is a sheet." Speech Therapist #4 indicated to the resident that she would help her with the report. Speech Therapist #4 indicated that she wrote exactly what the resident said that (CNA #3) hurt her (upper) arm and talked mean to her. Speech Therapist #4 indicated CNA #3 walked by and the resident pointed at CNA #3 and said,"there she is." Speech Therapist #4 indicated she went immediately to her supervisor and			

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	her supervisor immediately reported to the charge nurse and the charge nurse went immediately to CNA #3. Speech Therapist #4 indicated she then went to lunch and when she returned CNA #3 was out of the building. Speech Therapist #4 indicated the resident told her that she told CNA #3 she was too weak to stand up and CNA #3 said, "yes you can, yes you can." A copy of a "Concern Form" was provided by the DON on 03/17/11 at 11:00 a.m. This form indicated, "PT (Resident #A) requested assist from ST (Speech Therapy) to fill out form ...Concern: Pt (Resident #A) C/O (complained of) nursing aid grabbing her by arms & 'throwing me' onto toilet & 'talking mean.' C/O pain on (right) upper arm where she was 'grabbed.' Pt states staff member says 'Stand Up'! yes you can do it! Pt states she has explained her legs are very weak & that her legs will buckle. Pt was emotional and crying & states this			

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	happens 'over & over' & believes 'action' needs to take place. Department's response: Listen to patient's (Resident #A's) complaints. Reported to department nurse & rehab manager...Pt unable to state aid's name-- but was able to describe and point out specific aid." Interview of Physical Therapy Assistant (PTA) #5 on 03/17/11 at 10:25 a.m. indicated, the only thing she was aware of was when staff attempted to walk Resident #A the resident didn't want to walk. PTA #5 indicated the resident had previously been progressing well. PTA #5 indicated CNA#3 walked by and Resident #A said, "There she is, there she is, she doesn't want to help me." Interview of Certified Occupation Therapy Assistant (COTA) #6 on 03/17/11 at 10:30 a.m. indicated the resident had been toileted and then came to therapy. COTA #6			

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	indicated Resident #A told her, "Oh, honey that girl was mean. She talked mean & she hurt my arm. They need to give me more time." COTA #6 indicated she asked Resident #A who she was talking about and asked her to give some examples. COTA #6 indicated the resident said "she pulled my arm." COTA #6 indicated the resident described who the "girl" was. COTA #6 indicated she tried to walk the resident and the resident stood up and CNA #3 walked by and the resident indicated, "Oh my G-d honey there she is. She's the one." COTA #6 indicated the resident was then taken back to her room. An investigative sheet, dated 03/09/11, indicated, "On this date, (Resident #A) reported some complaints after the CNAs toileted her. PT (Resident #A) stated 'that one aide' is so rough with me and always grabs me by my arms. Shortly after these statements			

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	(Resident #A) was in the hallway to ambulate. (CNA#3) walked down the hall and (Resident #A) started pointing saying 'there she is, that's her!' This incident was in the presence of (COTA #6, ST #4, PTA #5, and LPN #2). Up to this date (Resident #A) had been able to (walk) 20 ft, however was so upset and fearful that therapist would hurt her (sic) also she required max assist of 2 to stand and unable to (walk). (Resident #A) reported to therapists that she would like to talk to someone about these concerns. Therapist assisted (Resident #A) in filling out concern form and reported to Rehab nurse (LPN #2)." Interview of the Director of Nursing (DON) on 03/17/11 at 10:40 a.m. indicated CNA #3 had a previous incident with a gentleman who was transferred to another facility but it was a "he said, she said" so was not validated. The DON indicated CNA #3 had problems in the past where she			

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	would be mouthy with staff in front of the residents, but would be counseled and then "would settle down." The DON indicated, "This is the first time I've had a resident point someone out to me and say, "she did this." The DON indicated the abuse occurred in the shower room and CNA #1 was present when it happened. The DON indicated CNA #1 did not report the abuse. The DON indicated therapy came to her and reported what the resident said. The DON indicated she was told by CNA #1 that the CNA said she was afraid to report what happened. The DON indicated the resident was confused but she told the same story 3 times. The DON indicated the resident had a bruise on her arm which looked like a "hand print" bruise. The DON indicated the CNA #3 denied it (Resident #A's allegation) but "I felt like it probably happened." The DON indicated she notified the Adult Protective Services (APS), the Ombudsman, and ISDH, but did			

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	not report the occurrence to the CNA registry. The DON indicated therapy came right to her (the DON) and CNA #3 was brought to her also and clocked out. The DON indicated Resident #A required a lot of assistance from staff and was confused and by the afternoon the resident could not remember what happened, but when asked if she was afraid of anything she said "only that 1 girl." The DON indicated a depression scale was completed on Resident #A that afternoon and her depression scale had increased since the last depression scale. The DON indicated she verbally told CNA #1 that she should always report any abuse or allegation of abuse to her charge nurse. The DON indicated she (the DON) had gone to CNA #1 for questioning regarding the resident's allegation. The DON indicated the CNA had not told anyone. Interview of CNA #1 on 03/17/11 at			

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	2:05 p.m. indicated, "Me (CNA #1) and (CNA #3) were taking (Resident #A) to the bathroom and (CNA #3) was yanking on (Resident #A) with the gait belt. (CNA #3) went to (answer) an alarm and when she came back - she point blank told (Resident #A) to 'stand her Fu----g a-s up.' Then she (CNA #3) told the resident she could stand up and pull her pants up herself. CNA #1 indicated after toileting the resident, she took the resident (in the resident's wheelchair) back to the nurse's station. (The nurse's station is an enclosed area with a window in the front.) CNA#3 indicated the nurse (LPN #2) "was in there but someone was with her." CNA #3 indicated she did not report the occurrence to the nurse but told the resident to tell the nurse. An investigative sheet (not dated) indicated, "I (CNA #1) was in the shower with (CNA#3) when (CNA #3) told (Resident #A) she was			

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	going to grab a hold of the gait belt and when she did (Resident #A) had a fit (because) she (CNA #3) moved her foot. So then (CNA #3) stood back and said she was tired of residents treatin (sic) her like sh-t and that we always get the blame for everything. Also she (CNA #3) told (Resident #A) on our second attempt to stand her up that we could not help her stand (sic) we could only use and hold onto the gait belt. She (CNA #3) said we don't have fu--ing time for this because we have other people to get up. So she told her (Resident #A) again after we sat her down again. (sic) To stand up, pull up her pants, and to get into her chair by herself, since she (Resident #A) thinks she can do everything herself! Then she said she didn't have times (sic) for games so we stood her up and pulled up her pants and put her in her chair! So then we took her out for breakfast. After we transferred her (Resident #A) to the toilet (sic) (CNA #3) left (Resident #A) in the			

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	bathroom with me (CNA #1) for a minute because she had to answer an alarm and (Resident #A) asked me (why) (CNA#3) was always this way towards her and how come she was hateful. I (CNA #1) told her I really didn't know but that she should tell her nurse when someone doesn't treat her right because that wasn't fair to her and that she doesn't derserve (sic) to be treated bad." Copies of investigative sheets related to the occurrence on 03/09/11 with CNA #3 and Resident #A were provided by the DON on 03/17/11 at 11:00 a.m. Interview of LPN #2 on 03/17/11 at 1:50 p.m. indicated, "(CNA#1) had the opportunity to tell me (what took place with CNA #3 and Resident #A). LPN #2 indicated she (LPN #2) was there. LPN #2 indicated if she hadn't been there the CNA should have told another nurse. LPN #2 indicated she first			

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	found out when the Therapy Department was attempting to get the resident to stand. LPN #2 indicated she also was trying to encourage the resident to stand and Resident #3 kept saying 'I'm afraid, I'm afraid.' LPN #2 indicated CNA#3 had been taking care of other residents and walked by (Resident #A) and the resident pointed out to (CNA #3) and said she was afraid of this CNA. Interview of Resident #A on 03/17/11 at 12:00 p.m. indicated the resident's care was going fine. The resident was smiling and cheerful at the time of the interview. The resident indicated there was one "girl" who "talked mean. She had terrible words coming out of her mouth...she was mad every time she came in. She came in with a bad attitude." The resident indicated, "I told and they fired her....you need to take this review and go through it." The resident indicated at the present time, "All the girls are real			

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	nice." A copy of a "FAX/INCIDENT REPORT" form was provided by the DON on 03/17/11 at 11:00 a.m.. This report indicated, "...Incident Date - 03/06/11...Staff noted a bruise approximately 14x11 cm (centimeters) on resident's upper left arm during care. Resident was admitted on 1/22/11 with edema, severe/extensive bruising, a fractured left humerus (arm), and a fractured left hip as a result of a fall prior to admission. The resident is alert with short term memory impairment and occasional confusion. Upon interview, resident denies any injury to left arm....The Administrator and Director of Nursing were notified as well as the Physician and family. The resident was assessed for pain. Interviews of staff working on this wing were initiated. In speaking with the family, they stated that (Resident #A) bruises very easily and has always done so. Preventive			

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	Measures Taken: The Director of Nursing or designee will monitor transfers of the resident and speak with Physical Therapy and Occupational Therapy to try to determine a cause. The resident is to have a CBC (complete blood count) and X-ray done on 3/7/11. This report copy was the "initial Report." A copy of a "FAX/INCIDENT REPORT" form was provided by the DON on 03/17/11 at 1:00 p.m. This report was a repeat of the above incident on 03/06/11. This report had additional information which included, "During investigation period, resident reported that one employee was 'rough' with her and had used her arms to transfer her causing pain in arms and resident stated that she was uncomfortable with this Q.M.A. (Qualified Medical Assistant) (CNA #3 was also a QMA) providing ADL care on her. This was reported to have occurred			

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	on the morning of 3/9/11. Further investigation initiated. This allegation directly correlates with the bruise on left upper arm. Interview with physical therapy, charge nurse and co-worker were completed." This report copy was the "Follow-up Report." A copy of a form titled "NOTICE OF DISCIPLINARY ACTION," dated 03/09/11, indicated termination of CNA #3. The form indicated, "...#1 Repeated allegation of verbal et (and) physical misconduct toward resident causing fear from resident. List of prior written warnings on file and date. 6/3/08 - attitude, 2/9/11...Failure to comply with other expectations for performance et behavior set forth in employee Handbook. Unprofessional/inappropriate behavior around residents (with) understanding that further incidents may result in termination. Describe in detail information you have			

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	available which supports taking the above course of action...(Resident #A's) allegations of physical et verbal inappropriateness (with) same resident currently having new bruising of right arm. Resident expresses fear of employee...." Review of Resident #A's clinical record on 03/17/11 at 11:25 a.m. indicated the following: Resident #A had diagnoses which included, but were not limited to, chronic obstructive pulmonary disease, osteoarthritis, dementia, history of falls, left hip fracture 1/19/11, peripheral vascular disease, chronic oxygen use, and intra cerebral bleed. An MDS (minimum data set) assessment, dated 01/28/11, indicated Resident #A's cognitive status was moderately impaired and Resident #A required extensive assistance with transfers, bathing, and toileting.			

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	A copy of a policy titled "Hoosier Enterprises Procedure Resident Abuse" was provided by the DON on 03/17/11 at 11:00 a.m. This policy indicated, "Purpose: To assure appropriate interventions are in place and followed if resident abuse is suspected or identified...Procedure: If resident abuse, or suspicion of abuse is reported: 1. The resident(s) involved in the incident will be removed from the situation at once...The individual who witnessed the incident shall immediately notify a charge nurse of the nursing unit which the resident occupies. If this is not feasible due to circumstances, the individual shall be responsible to notify any other nurse currently on duty. The charge nurse will examine the resident involved to determine if physical injuries have occurred and their extent. The charge nurse is responsible to notify the facility Administrator and			

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	Director of Nursing immediately...Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed...." This federal tag is related to Complaint IN00087294. 3.1-28(c)			

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F0226 SS=D	Based on interview and record review, the facility failed to ensure a resident's (Resident #A) allegation of staff verbal and physical abuse was reported immediately according to facility policy and procedures. This affected 1 of 5 residents reviewed for abuse allegations in a sample of 11. Findings include: Interview of LPN (charge nurse) #2 on 03/17/11 at 9:10 a.m. indicated LPN #2 observed therapy working with Resident #A on 03/09/11. Therapy was attempting to get the resident to stand. LPN #2 indicated she (LPN #2) also was encouraging the resident to stand. LPN #2 indicated CNA #3 walked by, and Resident #A pointed to the CNA #(3) and said, "There she is." Interview of LPN #2 on 03/17/11 at 12:20 p.m. indicated on 03/09/11 Resident #A had eaten breakfast	F0226	F226 DEVELOP/IMPLEMENT POLICIES/PROCEDURES PREVENT MISTREATMENT/NEGLECT/ABUSEThe facility will ensure this requirement is met through the following corrective measures:1. Resident #A was not harmed.2. All residents have the potential to be affected. Residents were interviewed as part of the facility's investigation and no concerns were noted at this time. 3. The Policy and Procedure for Resident Abuse and for Reporting Unusual Occurrences was reviewed and no changes are indicated. The staff have been re-educated on the policies and procedures for reporting abuse (See Attachment A). All allegations of abuse will be reported immediately by staff to the Administrator. One staff member will be questioned by the Administrator or his designee daily on scheduled work days x4 weeks, then two times weekly x 4 weeks, and then twice monthly thereafter to ensure continued compliance (See Attachment B).4. The findings of these interviews will be reviewed during the facility's quarterly Quality Assurance Meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 3/31/11.	03/31/2011

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	before CNA #1 and CNA #3 toileted the resident. LPN #2 indicated breakfast was served between 8:00 and 9:00 a.m., and the resident was taken to therapy at approximately 10:00 a.m. LPN #2 indicated CNA #1 and CNA #3 had toileted the resident before therapy. LPN #2 indicated CNA #1 was not standing nearby when the resident pointed and accused CNA #3. LPN #2 indicated CNA #1 did not report anything to LPN #2. LPN #2 indicated the CNAs were aware they were supposed to report any type of abuse immediately to the charge nurse and "for something as urgent as this" they definitely should report it. LPN #2 said, "I am always here (on the unit Resident #A) resided and if for some reason I am not here they know to report it to someone. LPN #2 indicated CNA #3 continued to work and take care of other residents after toileting Resident #A.			

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	An investigative sheet, dated 03/09/11, indicated, "To whom concerned, Resident (#A) confided in me that (CNA #3) was being mean to her this morning during transfers and ADL (activities of daily living) care. (Resident #A) stated to me 'this morning when I was getting up out of bed they pulled my arms and that (CNA #3) said Je--s Chr---, if you don't do it now you never will.' I asked (Resident #A) if her belt (gait belt) was on and she said 'yes but the (sic) still pull on my arms especially that one' (points to CNA #3). 'When I was in the wash room this morning they were again pulling on my arms and I keep telling them it hurts' (sic) (Resident #A) could not state (CNA #3's) name but when passed her in the hall she pointed at her and said 'see there she goes, get her away from me, I'm afraid of her.'" This statement was signed by LPN #2 (Charge Nurse on the hall where Resident #A resided).			

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	Interview of the Administrator on 3/17/11 at 11:40 a.m. indicated CNA #3 was released for unprofessional behavior. Interview of Speech Therapist #4 on 03/17/11 at 10:20 a.m. indicated Resident #A was brought to Speech Therapist #4 after being toileted. Speech Therapist #4 indicated, "I could tell (Resident #A) was a little upset. I asked if she (Resident #A) was ok and (Resident #A) said that nurse and described her and I knew who it was by the description and then (Resident #A) said, "Can I write a report if there is a sheet." Speech Therapist #4 indicated to the resident that she would help her with the report. Speech Therapist #4 indicated that she wrote exactly what the resident said that (CNA #3) hurt her (upper) arm and talked mean to her. Speech Therapist #4 indicated CNA #3 walked by and the resident pointed at CNA #3 and said,"there she is." Speech			

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	Therapist #4 indicated she went immediately to her supervisor and her supervisor immediately reported to the charge nurse and the charge nurse went immediately to CNA #3. Speech Therapist #4 indicated she then went to lunch and when she returned CNA #3 was out of the building. Speech Therapist #4 indicated the resident told her that she told CNA #3 she was too weak to stand up and CNA #3 said, "yes you can, yes you can." A copy of a "Concern Form" was provided by the DON on 03/17/11 at 11:00 a.m. This form indicated, "PT (Resident #A) requested assist from ST (Speech Therapy) to fill out form ...Concern: Pt (Resident #A) C/O (complained of) nursing aid grabbing her by arms & 'throwing me' onto toilet & 'talking mean.' C/O pain on (right) upper arm where she was 'grabbed.' Pt states staff member says 'Stand Up'! yes you can do it! Pt states she has explained her legs are very weak &			

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	that her legs will buckle. Pt was emotional and crying & states this happens 'over & over' & believes 'action' needs to take place. Department's response: Listen to patient's (Resident #A's) complaints. Reported to department nurse & rehab manager...Pt unable to state aid's name-- but was able to describe and point out specific aid." Interview of Physical Therapy Assistant (PTA) #5 on 03/17/11 at 10:25 a.m. indicated, the only thing she was aware of was when staff attempted to walk Resident #A the resident didn't want to walk. PTA #5 indicated the resident had previously been progressing well. PTA #5 indicated CNA#3 walked by and Resident #A said, "There she is, there she is, she doesn't want to help me." Interview of Certified Occupation Therapy Assistant (COTA) #6 on 03/17/11 at 10:30 a.m. indicated the			

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	resident had been toileted and then came to therapy. COTA #6 indicated Resident #A told her, "Oh, honey that girl was mean. She talked mean & she hurt my arm. They need to give me more time." COTA #6 indicated she asked Resident #A who she was talking about and asked her to give some examples. COTA #6 indicated the resident said "she pulled my arm." COTA #6 indicated the resident described who the "girl" was. COTA #6 indicated she tried to walk the resident and the resident stood up and CNA #3 walked by and the resident indicated, "Oh my G-d honey there she is. She's the one." COTA #6 indicated the resident was then taken back to her room. An investigative sheet, dated 03/09/11, indicated, "On this date, (Resident #A) reported some complaints after the CNAs toileted her. PT (Resident #A) stated 'that one aide' is so rough with me and			

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	always grabs me by my arms. Shortly after these statements (Resident #A) was in the hallway to ambulate. (CNA#3) walked down the hall and (Resident #A) started pointing saying 'there she is, that's her!' This incident was in the presence of (COTA #6, ST #4, PTA #5, and LPN #2). Up to this date (Resident #A) had been able to (walk) 20 ft, however was so upset and fearful that therapist would hurt her (sic) also she required max assist of 2 to stand and unable to (walk). (Resident #A) reported to therapists that she would like to talk to someone about these concerns. Therapist assisted (Resident #A) in filling out concern form and reported to Rehab nurse (LPN #2)." Interview of the Director of Nursing (DON) on 03/17/11 at 10:40 a.m. indicated CNA #3 had a previous incident with a gentleman who was transferred to another facility but it was a "he said, she said" so was not validated. The			

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	DON indicated CNA #3 had problems in the past where she would be mouthy with staff in front of the residents, but would be counseled and then "would settle down." The DON indicated, "This is the first time I've had a resident point someone out to me and say, "she did this." The DON indicated the abuse occurred in the shower room and CNA #1 was present when it happened. The DON indicated CNA #1 did not report the abuse. The DON indicated therapy came to her and reported what the resident said. The DON indicated she was told by CNA #1 that the CNA said she was afraid to report what happened. The DON indicated the resident was confused but she told the same story 3 times. The DON indicated the resident had a bruise on her arm which looked like a "hand print" bruise. The DON indicated the CNA #3 denied it (Resident #A's allegation) but "I felt like it probably happened." The DON indicated she notified the			

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	Adult Protective Services (APS), the Ombudsman, and ISDH, but did not report the occurrence to the CNA registry. The DON indicated therapy came right to her (the DON) and CNA #3 was brought to her also and clocked out. The DON indicated Resident #A required a lot of assistance from staff and was confused and by the afternoon the resident could not remember what happened, but when asked if she was afraid of anything she said "only that 1 girl." The DON indicated a depression scale was completed on Resident #A that afternoon and her depression scale had increased since the last depression scale. The DON indicated she verbally told CNA #1 that she should always report any abuse or allegation of abuse to her charge nurse. The DON indicated she (the DON) had gone to CNA #1 for questioning regarding the resident's allegation. The DON indicated the CNA had not told anyone.			

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	Interview of CNA #1 on 03/17/11 at 2:05 p.m. indicated, "Me (CNA #1) and (CNA #3) were taking (Resident #A) to the bathroom and (CNA #3) was yanking on (Resident #A) with the gait belt. (CNA #3) went to (answer) an alarm and when she came back - she point blank told (Resident #A) to 'stand her Fu----g a-s up.' Then she (CNA #3) told the resident she could stand up and pull her pants up herself. CNA #1 indicated after toileting the resident, she took the resident (in the resident's wheelchair) back to the nurse's station. (The nurse's station is an enclosed area with a window in the front.) CNA#3 indicated the nurse (LPN #2) "was in there but someone was with her." CNA #3 indicated she did not report the occurrence to the nurse but told the resident to tell the nurse. An investigative sheet (not dated) indicated, "I (CNA #1) was in the			

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	shower with (CNA#3) when (CNA #3) told (Resident #A) she was going to grab a hold of the gait belt and when she did (Resident #A) had a fit (because) she (CNA #3) moved her foot. So then (CNA #3) stood back and said she was tired of residents treatin (sic) her like sh-t and that we always get the blame for everything. Also she (CNA #3) told (Resident #A) on our second attempt to stand her up that we could not help her stand (sic) we could only use and hold onto the gait belt. She (CNA #3) said we don't have fu--ing time for this because we have other people to get up. So she told her (Resident #A) again after we sat her down again. (sic) To stand up, pull up her pants, and to get into her chair by herself, since she (Resident #A) thinks she can do everything herself! Then she said she didn't have times (sic) for games so we stood her up and pulled up her pants and put her in her chair! So then we took her out for breakfast. After we transferred			

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	155145	A. BUILDING _____ B. WING _____	03/17/2011

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	her (Resident #A) to the toilet (sic) (CNA #3) left (Resident #A) in the bathroom with me (CNA #1) for a minute because she had to answer an alarm and (Resident #A) asked me (why) (CNA#3) was always this way towards her and how come she was hateful. I (CNA #1) told her I really didn't know but that she should tell her nurse when someone doesn't treat her right because that wasn't fair to her and that she doesn't derserve (sic) to be treated bad." Copies of investigative sheets related to the occurrence on 03/09/11 with CNA #3 and Resident #A were provided by the DON on 03/17/11 at 11:00 a.m. Interview of LPN #2 on 03/17/11 at 1:50 p.m. indicated, "(CNA#1) had the opportunity to tell me (what took place with CNA #3 and Resident #A). LPN #2 indicated she (LPN #2) was there. LPN #2 indicated if she hadn't been there			

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	the CNA should have told another nurse. LPN #2 indicated she first found out when the Therapy Department was attempting to get the resident to stand. LPN #2 indicated she also was trying to encourage the resident to stand and Resident #3 kept saying 'I'm afraid, I'm afraid.' LPN #2 indicated CNA#3 had been taking care of other residents and walked by (Resident #A) and the resident pointed out to (CNA #3) and said she was afraid of this CNA. Interview of Resident #A on 03/17/11 at 12:00 p.m. indicated the resident's care was going fine. The resident was smiling and cheerful at the time of the interview. The resident indicated there was one "girl" who "talked mean. She had terrible words coming out of her mouth...she was mad every time she came in. She came in with a bad attitude." The resident indicated, "I told and they fired her....you need to take this review and go through			

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	it." The resident indicated at the present time, "All the girls are real nice." A copy of a "FAX/INCIDENT REPORT" form was provided by the DON on 03/17/11 at 11:00 a.m.. This report indicated, "...Incident Date - 03/06/11...Staff noted a bruise approximately 14x11 cm (centimeters) on resident's upper left arm during care. Resident was admitted on 1/22/11 with edema, severe/extensive bruising, a fractured left humerus (arm), and a fractured left hip as a result of a fall prior to admission. The resident is alert with short term memory impairment and occasional confusion. Upon interview, resident denies any injury to left arm....The Administrator and Director of Nursing were notified as well as the Physician and family. The resident was assessed for pain. Interviews of staff working on this wing were initiated. In speaking with the family, they stated that			

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	(Resident #A) bruises very easily and has always done so. Preventive Measures Taken: The Director of Nursing or designee will monitor transfers of the resident and speak with Physical Therapy and Occupational Therapy to try to determine a cause. The resident is to have a CBC (complete blood count) and X-ray done on 3/7/11. This report copy was the "initial Report." A copy of a "FAX/INCIDENT REPORT" form was provided by the DON on 03/17/11 at 1:00 p.m. This report was a repeat of the above incident on 03/06/11. This report had additional information which included, "During investigation period, resident reported that one employee was 'rough' with her and had used her arms to transfer her causing pain in arms and resident stated that she was uncomfortable with this Q.M.A. (Qualified Medical Assistant) (CNA #3 was also a			

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	QMA) providing ADL care on her. This was reported to have occurred on the morning of 3/9/11. Further investigation initiated. This allegation directly correlates with the bruise on left upper arm. Interview with physical therapy, charge nurse and co-worker were completed." This report copy was the "Follow-up Report." A copy of a form titled "NOTICE OF DISCIPLINARY ACTION," dated 03/09/11, indicated termination of CNA #3. The form indicated, "...#1 Repeated allegation of verbal et (and) physical misconduct toward resident causing fear from resident. List of prior written warnings on file and date. 6/3/08 - attitude, 2/9/11...Failure to comply with other expectations for performance et behavior set forth in employee Handbook. Unprofessional/inappropriate behavior around residents (with) understanding that further incidents			

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	may result in termination. Describe in detail information you have available which supports taking the above course of action...(Resident #A's) allegations of physical et verbal inappropriateness (with) same resident currently having new bruising of right arm. Resident expresses fear of employee...." Review of Resident #A's clinical record on 03/17/11 at 11:25 a.m. indicated the following: Resident #A had diagnoses which included, but were not limited to, chronic obstructive pulmonary disease, osteoarthritis, dementia, history of falls, left hip fracture 1/19/11, peripheral vascular disease, chronic oxygen use, and intra cerebral bleed. An MDS (minimum data set) assessment, dated 01/28/11, indicated Resident #A's cognitive status was moderately impaired and Resident #A required extensive			

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	assistance with transfers, bathing, and toileting. A copy of a policy titled "Hoosier Enterprises Procedure Resident Abuse" was provided by the DON on 03/17/11 at 11:00 a.m. This policy indicated, "Purpose: To assure appropriate interventions are in place and followed if resident abuse is suspected or identified...Procedure: If resident abuse, or suspicion of abuse is reported: 1. The resident(s) involved in the incident will be removed from the situation at once...The individual who witnessed the incident shall immediately notify a charge nurse of the nursing unit which the resident occupies. If this is not feasible due to circumstances, the individual shall be responsible to notify any other nurse currently on duty. The charge nurse will examine the resident involved to determine if physical injuries have occurred and their extent. The			

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	charge nurse is responsible to notify the facility Administrator and Director of Nursing immediately...Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed...." This federal tag is related to Complaint IN00087294. 3.1-28(a)			